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In addition to the categories listed above, the Division of Medical Assistance has instituted a questionnaire, with 5 2-part questions, for self-identification of children with Special Health Care Needs at the time of enrollment in Medicaid or Health Choice (SCHIP). This information is captured in the Eligibility Information System (EIS) to assist with reporting and monitoring of CSHCN.

The State has an internal exemption process that approves or denies Medicaid recipients' exemption requests from participation in our PCCM option for medical reasons. The medical exemption requests are reviewed and approved by the Quality Management unit. Recipient who have ESRD, terminal illness or require hospice services are automatically made exempt by the State.

An exemption is deemed necessary when it is determined that in order to maintain continuity of care it would be necessary to medically exempt the recipient from the PCCM health care option. The recipient and the county DSS office are notified in writing of the approval or denial of an exemption request.

Recipients may request a disenrollment from the MCO at any time for any reason. The State's contract with the MCO clearly states the recipient's right to voluntarily disenroll at any time without cause.

5. How does the State identify the following groups who are exempt from mandatory enrollment into managed care:

   a. Individuals who are also eligible for Medicare.

      These recipients are identified by Medicaid eligibility category of assistance.

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b. There is no eligibility category group designated for the Native American population; they are eligible for Medicaid under existing program aid categories. When a Native American applies for Medicaid, he is automatically exempted from enrollment into managed care based on his membership in a federally recognized tribe and not on his eligibility group.

E. LIST OTHER POPULATIONS (NOT PREVIOUSLY MENTIONED) WHO ARE EXEMPT FROM MANDATORY ENROLLMENT.

There are no other exempt populations (not previously mentioned).

V. ENROLLMENT PROCESS

A. DEFINITIONS

An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

B. STATE PROCESS FOR ENROLLMENT BY DEFAULT

1. Describe how the state's default enrollment process will preserve:

   a. the existing provider-recipient relationship;
   b. the relationship with providers that have traditionally served Medicaid recipients;

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c. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702 (a)(4)), disenrollment for cause in accordance with 42 CFR 438.56(d)(2). and;
d. The division strives to minimize the use of auto-assignments.

The caseworkers in each local county Department of Social Services (DSS) are responsible for auto-assigning in all counties excluding Mecklenburg County. An enrollment broker, Public Consulting Group (PCG), handles auto assignments in Mecklenburg County.

The State assures that default enrollment will be based first upon maintaining existing provider-patient relationships. Most beneficiaries receive education as to their managed care options verbally through staff at their respective county DSS. Inquiries are made for potential default enrollment as to current provider-patient relationships when recipients do not select a primary care provider or HMO at the time of the visit. Some beneficiaries, particularly Supplemental Security Income (SSI) recipients, do not visit the social services office for Medicaid application and/or reapplication. In these cases, written materials describing the managed care options are mailed to them along with a deadline for notification of PCP/MCO selection.

Attempts are made to contact beneficiaries by telephone or letter if they do not respond within the time frame; inquiries are made about existing relationships with providers when contact is made.

If it is not possible to obtain provider-patient history, beneficiaries are assigned to providers based upon equitable distribution among participating Managed Care Entities (MCEs), including PCPs and the MCO (Mecklenburg County only) as available in the recipient's county of residence.

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Caseworkers are told to look at the provider restrictions, e.g. patients 21 and under or established patients only, listed in the State Eligibility Information System (EIS), and geographical proximity to the provider before auto assigning a recipient.

2. As part of the state's discussion on the default enrollment process, include the following items:
   a. the time frame for recipients to choose a health plan before being auto-assigned;
   b. the State's process for notifying Medicaid recipients of their auto-assignment;
   c. the State's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment if the default assignment process is problematic for the beneficiary.
   d. a description of the default assignment algorithm used for auto-assignment
   e. how the State will monitor any changes in the rate of default assignment

   Recipients are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI recipients do not apply for Medicaid, they are listed on a report. When they become eligible for Medicaid, a letter is sent to them asking them to contact DSS to select a PCP. The report is monitored to determine if SSI recipients are getting enrolled.

   The county DSS or PCG staff reviews the SSI exempt report and auto-assign all recipients who have been on the report for 30 days or more and assigns them to a PCP. Counties then send a letter to the recipient informing them of their PCP along with a copy of the recipient handbook.

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Recipients in Mecklenburg County are assigned to a provider by using an algorithm that includes paid claims information on each recipient. Data on recipients who are eligible for automatic assignment is run to determine if the recipient has any PCP paid claims. If the data on a recipient show more than one PCP with a paid claim, the PCP with the highest frequency of visits is determined to be the PCP of choice. The
PCP of choice is subsequently compared to the provider directory file for a match, and then it is determined if the MCO or PCCM has the PCP in their networks.

Paid claims history is searched to determine if the recipient had any visits to specialists. If the recipient's data show more than one specialist with paid claims, the specialist with the highest frequency of visits is selected as the specialist of choice.

Paid claims history is searched to determine if the recipient had any hospital visits. If there is a hospital claim and if the MCO or PCCM has the hospital in their network, it is allowed to remain as a possible assignment.

If no claims were paid to PCPs or specialists, and only hospital claims existed, then the MCO or PCCM with that hospital in their network, is allowed to remain as possible assignment.

If no paid claims history exists, the recipient is assigned according to the algorithm assignment used for the general population.

C. STATE ASSURANCES ON THE ENROLLMENT PROCESS

1. The State Plan program assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

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2. The State Plan program assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 412.62 (f)(1)(ii).

   X The State Plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs. (Place check mark to indicate state's affirmation.)

3. The State plan program will only limit enrollment into a single HIO, if and only if the HIO is one of the entities described in section 1932 (a)(3) (C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

D. DISENROLLMENT

1. The State Plan program assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56 (c).

   The State assures that beneficiaries will be permitted to disenroll from a managed care plan or change Carolina ACCESS/ACCESS II PCPs on a month to month basis. However, the recipient must select another managed care plan option for health care services, if the recipient is in one of the mandatory eligibility categories for enrollment. The county DSS is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the State eligibility system.

2. What are the additional circumstances of "cause" for disenrollment? (If any.)

VI. INFORMATION REQUIREMENTS FOR BENEFICIARIES

The State Plan program assures that its plan is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932 (a)(1)(A) state plan amendments.

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The State assures that it will provide information to beneficiaries in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, and benefits not covered by the MCE. The State provides comparative information on benefits and cost sharing, service areas, and the special features of each MCE. The State assures CMS that it will also provide comparative information on quality and performance of participating managed care entities to the extent that this information is available. All information will be written in language at the fifth grade level of reading comprehension.

Marketing materials for PCCM potential enrollees are provided by the State. The State's risk contract with the MCO allows the MCO to develop marketing materials and engage in marketing activities in accordance with requirements stated in 42 C.F.R. 438.104.

VII. DESCRIPTION OF EXCLUDED SERVICES FOR EACH MODEL (MCO & PCCM)

The excluded services for the MCO model, referred to as Out-of-Plan Benefits, are listed below:

CAP Services
At-Risk Case Management
Child Service Coordination
Dental
D.S.S. Non-Emergency Transportation
Developmental Evaluation Center Services
HIV Case Management
ICF/MR
Maternity Care Coordination
Mental Health and Substance Abuse Mental Health – Inpatient &Outpatient
Personal Care Services
Prescription Drugs
School-Related and Head Start Therapies
Skilled or Intermediate Nursing Care

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The following Carolina ACCESS and ACCESS II exempt services do not require PCPs authorization:

Ambulance
Anesthesiology
At Risk Case Management
CAP Services
Certified Nurse Anesthetist
Child Care Coordination Services
Dental
Developmental Evaluation Centers
Diagnosis and treatment of emergency conditions
Eye exam for glasses
Family Planning
Head Start Programs
Health Department Services
Hearing Aids
Hospice
Laboratory Services
Maternity Care Coordination
Mental Health
Optical Supplies/Visual Aids
Pathology Services
Pharmacy
School Services
X-Ray Services not done in the Hospital

VIII. SANCTIONS

Describe how the program will implement Subpart I of 42 CFR 438 and monitor for violations that involve the actions and failures in this subpart to acts specific in this subpart (42 CFR 438.726 (a)).

Contractual noncompliance issues or access problems that are detected in the PCCM program as a result of recipient surveys or recipient complaints are addressed in a number of ways, depending on the nature and urgency of the problem. Generally, contact is made with the provider to evaluate the issue; depending on the outcome of the evaluation, a corrective action plan might be implemented and/or the provider might be sanctioned. An example of a sanction would be suspension of management fees or restricting the provider from taking on additional Carolina ACCESS patients.

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The State monitors the MCO for violations through periodic reviews including onsite audits, recipient or other complaints, financial status or any other source. Intermediate sanctions may be imposed for the reasons and in the manner outlined in 42 C.F.R. 438.702 and 42 C.F.R. 438.704.

The State shall impose temporary management if it finds that the MCO has repeatedly failed to meet the substantive requirements in section 1903(m) or 1932 of the Social Security Act. The State will grant enrollees the right to disenroll without cause and will notify them of this right.

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MARCH 1993

State: North Carolina

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1	(b)(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date if prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under Section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and 1920 of the Act	x	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.